

**To assess the attitudes of top management/CEO's of small building companies, towards
the implementation of HIV/AIDS workplace policies**

by

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

Throughout this piece of work, the author has considered the attitudes of chief executive officers/top management of small building companies' within the southern suburbs of Cape Town, towards the implementation of HIV/AIDS workplace policies. This became of interest to the researcher whilst studying for the postgraduate diploma in the management of HIV/AIDS in the workplace, as the company used throughout this diploma was a small building company. As Human Resource Manager for this company, employing between 15-30 men, it became apparent how difficult it is for small companies to consider HIV/AIDS as a workplace issue. This became even more of a concern whilst considering how many people are employed by small companies especially within the construction industry which is uniquely vulnerable. Top management support is imperative to implementing an active HIV/AIDS workplace policy therefore assessing how they consider it and what barriers they face was believed to be significant if a cohesive strategic response was to be formulated. A survey was deemed the most appropriate way to gain this insight which the researcher carried out. The results highlighted how small businesses within the construction industry are not addressing HIV/AIDS as a workplace issue despite recognising it as a significant threat. The researcher then considers several options on how to overcome these barriers.

Opsomming

Die doel van die navorsing was om die houdings van hoof uitvoerende beamptes/topbestuur van klein boumaatskappye te bepaal teenoor die implementering van 'n MIV/Vigs beleid in hul werksplekke. Die studie het binne die suidelike voorstede van Kaapstad plaasgevind. Die navorser het in die onderwerp begin belangstel terwyl sy vir 'n nagraadse diploma in MIV/Vigsbestuur ingeskryf was en sy 'n klein boumaatskappy tydens haar studie gebruik het vir data insameling ter voltooiing van haar werkstukke. As Menslike Hulpbronbestuurder van die maatskappy, wat tussen 15-30 mans indiens het, het dit vir die navorser duidelik geword hoe moeilik dit vir klein maatskappye is om MIV/Vigs as 'n bedreiging in die werkplek te sien.

Dit was nog meer kommerwekkend om te sien hoeveel mense deur klein maatskappye indiens geneem word, veral in die konstruksiebedryf wat baie kwesbaar is. Topbestuur se ondersteuning is van kardinale belang vir die implementering van MIV/Vigs werksplekprogramme, daarop dat dit belangrik is om te bepaal hoe hul dit ervaar en watter struikelblokke hul ondervind. Die navorser het inligting ingesamel deur 'n vraelys aan die respondente uit te deel.

Die resultate beklemtoon dat klein maatskappye binne die konstruksiebedryf nie MIV/Vigs kwessies aanspreek nie, ten spyte van die feit dat hul dit as 'n bedreiging beskou. Die navorser stel verskeie opsies voor om die struikelblokke so ver moontlik te oorkom.

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1. Research overview

1.1 Working title

To assess the attitudes of top management/CEO's of small building companies towards implementing HIV/AIDS workplace policies.

1.2 Background to study

No-one could have associated the significance of the first reported deaths of a handful of young men in the USA, from a fatal form of pneumonia, with the estimated deaths of 23 million people from what is now known as Acquired Immune Deficiency Syndrome (AIDS). Globally 39.4 million people are now living with Human Immunodeficiency Syndrome (HIV), with 22.5 million, i.e. 68% of them residing in Sub-Saharan Africa (UNAIDS, 2010). The most alarming characteristic of this virus is that it defies the "laws of epidemics" with its persistent increase in numbers, resulting in it becoming a globally devastating pandemic. Of extreme concern is the lack of a cure or the existence of an effective vaccine, therefore allowing it to become an overwhelming omnipresent reality. South Africa has the highest incidence of HIV/AIDS in the world, with an estimated 5.6 million people infected in 2009 with Sub-Saharan Africa accounting for 72% of the global death total (UNAIDS, 2011). The asymptomatic nature of this disease is the secret to its success, with its presence shaping the future of mankind in an unprecedented manner. The catastrophic impact this virus is having can be illustrated by the suggestion, if there is no forthcoming effective intervention, South Africa alone could lose 40-50% of its workforce over the next ten years (Whiteside, 2005 as cited in van Niekerk & Kopelman, 2005). This HIV/AIDS epidemic impacts on all spheres of life however, it significantly affects the working age group, those between 15 and 49 and therefore it will and is affecting the world of work.

HIV/AIDS is a pandemic with serious implications for South Africa in general but specifically the South African construction industry. The Construction Industry Development Board in 2003 emphasized:

"Research indicates that the South African construction industry has the third highest incidence rate of HIV/AIDS in South Africa. The construction sector has a predominately migratory labour force, making it a prime contributor to the spread of HIV/AIDS. This being

compounded by the situation where migration workers on contracts generally ignore, or are ignorant of the consequences of casual sexual relationships”.

The construction industry is a crucial part of the South African economy with it contributing 4% of the national GDP (Statistics South Africa, 2008). Against a background of acute shortage of houses and infrastructure provision, the finance minister Pravin Gordham, in his 2010 budget speech outlined plans to spend R846 billion on infrastructure programmes over the next three years. However, the prevalence of HIV/AIDS amongst construction workers is impacting negatively on its ability to deliver with political ambivalence being a major stumbling block (Bowen, 2007). A Global Construction Survey (2009) released its finding which suggested the industry battled to find enough high quality employees yet the Bureau for Economic Research 2005 survey highlighted the lack of response by the construction industry to the HIV/AIDS epidemic, with less than a third of companies implementing an HIV/AIDS workplace policy. What it also discovered was larger companies were far more likely to have implemented HIV/AIDS policies, around 90% whilst only 20% of the smaller companies had a policy. Respondents from some smaller companies commented they did not believe they will be affected by HIV/AIDS, feeling only large companies will have labour and financial concerns. Others remarked they simply did not have the resources available to implement and sustain HIV/AIDS programmes suggesting they deal with it in bite sizes via surveys and awareness campaigns when finances allow and feel government should offer incentives to encourage these interventions.

The Western Cape has the lowest percentage of companies to have implemented HIV/AIDS programmes. Only 44% of those surveyed implemented HIV/AIDS awareness campaigns, 20% offered voluntary counselling and testing (VCT), 17% offer care, support and treatment and only 6% offer anti-retroviral treatment. Within the construction industry, only 8% had conducted any research to assess the impact of HIV/AIDS on their labour force compared to 63% of the financial sector and only 3% had considered the effects on their production costs. Once again, small companies had participated far less in any risk assessment compared to their larger counter part (Bureau for Economic Research, 2004).

1.3. Research problem

At present there is no cohesive response for small businesses within the construction industry for managing HIV/AIDS in the workplace. Previous research has suggested some of the

problems stems from under estimating the impact HIV/AIDS will have on the industry, small companies not considering it their concern, lack of resources and time, HIV is a sensitive subject, the sexual behaviour of employees is not the company's problem and often small building companies work in the informal sector (Bakuwa, 2010).

The construction industry is uniquely vulnerable to the pandemic but there is limited industry-specific research available (Bowen, 2007). Therefore, the researcher wishes to investigate what barriers there are for small business within the construction sector, specifically in Cape Town, in developing HIV/AIDS workplace policies. If this question can be answered the researcher would be able to provide guidelines on how to overcome these barriers. Both employers and employees will benefit from this information.

1.4 Significance of the study

By undertaking this study the researcher aims to gain an insight into the barriers small building companies, specifically in the southern suburbs of Cape Town, face whilst considering HIV/AIDS in their workplace. Whilst contemplating this topic, it would appear at present HIV/AIDS within small to medium sizes business (SMSB) it is not considered a workplace concern. This is evident by the lack of any formal policies in place as only 13% of small companies surveyed by The World Economic Forum, Business and HIV/AIDS (2005-2006) had a policy. Larger companies appear to be more proficient in providing policies which initially makes sense as large corporations have far more resources. However, with 70% of all Sub-Saharan Africans being employed by SMSB (McGreevey, Albenbrack, & Stover, 2003) it would appear this is the very group of employers whom should be addressing this crisis and are in an ideal position to do so. The business community is in a unique position to make a difference in facing up to the epidemic of HIV/AIDS by developing work place programmes but despite the documented effects this virus may have on the economy, business is still greatly underestimating the impact (South African Business Coalition on HIV/AIDS, SABCOHA, 2009).

Beresford wrote in The Mail and Guardian, (May 17th 2002) that 75% of small companies had not embarked on any prevention programmes but warned the cost of doing nothing could be severe. For these reasons, the researcher believes the answer to this question posed may provide valuable insight into an area of crucial importance. With these answers the researcher

intends to make recommendations to small construction companies on how to address HIV/AIDS in the workplace.

1.5 Research question

What are the attitudes of top management/CEOs of small building companies within the construction industry (with less than 50 employees) in relation to addressing HIV/AIDS in their workplace?

1.6 Aim and objectives

Aim

To establish factors influencing decision making in small/medium companies, within the construction industry of Cape Town, in relation to address HIV/AIDS in the workplace, in order to provide support to these companies to help deliver practical HIV/AIDS workplace policies.

Objectives

- To establish the views of employers within small businesses, on the implementation of a workplace HIV/AIDS policy.
- To identify barriers small businesses may encounter whilst trying to implement a HIV/AIDS workplace policy
- To provide guidelines on how small businesses may overcome these barriers.

2. Literature review

Within this literature review, the researcher will firstly consider HIV/AIDS globally, in Africa and then more specifically within Southern Africa. This will be followed by the economic impact of HIV/AIDS within Southern Africa, particularly considering the construction industry and small businesses. The literature surrounding these issues shall be discussed with reference to its important with reference to the workplace. Finally, the researcher shall discuss the findings from previous studies on HIV/AIDS policies in the workplace, whether there are policies, how they are developed, implemented and whether it was a success.

2.1 The global impact of HIV/AIDS

Combating HIV/AIDS, malaria and other diseases is one of the eight United Nations Millennium Development Goals formulated in 2000 which demonstrates the global alarm this virus has triggered. According to the latest World Health Organisation (WHO) report (2010), the overall growth of the global epidemic appears to have stabilised. The introduction of antiretroviral therapy has resulted in fewer AIDS-related deaths and the annual number of new HIV infection has been progressively declining since the late 1990 (WHO, 2010). In 2009 there was a 19% decrease in people who became newly infected than in 1999 with 33 countries seeing the HIV incidence rate fall more than 25% between 2001 and 2009. In spite of these findings, it has been estimated there were still 2.6 million new infections in 2009 indicating overall new infection rates are still high and with a significant reduction in mortality, the number of people actually living with HIV has increased from UNAIDS estimates of 33.3 million 2009 compared with 26.2 million 1999.

2.2 HIV/AIDS in Africa

Within Africa, the WHO (2012) reported HIV/AIDS as the leading cause of death and with an estimated 2.7 million new infections in 2010, (down by 26% from 1997) the economic, social and human costs continue to remain an enormous challenge.

The picture in Africa is mixed with the first and most important point to recognise is there is no African epidemic but many epidemics. North Africa continues to have the lowest prevalence rates on the continent estimated at around 1%-2% but some countries do not report any cases in some cases being secondary to no functioning government to collect data. Within the West and Central Africa UNAIDS (2002) reported there are relatively low adult HIV prevalence rates, ranging from 1-1.7%. However, this can be surpassed by a more serious pattern emerging in countries such as Cameroon (11.8%), Central African Republic (12.9%), Cote d'Ivoire (9.7%) and Nigeria (5.8) (Van Niekerk & Kopelman, 2005). The Middle East and North Africa (MENA) are often grouped together because they have many things in common, for instance, almost everyone speaks Arabic and Islam is the dominant religion. It would therefore appear most data on the epidemic groups them together which shall be accepted and not discussed within this paper. Reliable data on the epidemic in the region of North Africa and the Middle East remains in short supply, creating difficulty in following recent trends with any certainty. Even so, with the evidence available, the number of new infection is on the increase with epidemics in the region typically concentrated among

injecting drug users, men who have sex with men, and sex workers and their clients (UNAIDS, 2010). It is estimated that some 75 000 people in the region are in need of antiretroviral therapy, but only 4 000 were receiving it at the end of 2005. Sudan has by far the biggest epidemic in this region with an adult HIV prevalence was 1.6% in 2005 and some 350 000 people were living with the HIV (UNAIDS, 2010). However disturbing as these finding are, they are almost inconsequential in comparison to the statistics within Sub-Saharan Africa.

2.3 Sub-Saharan Africa

Sub-Saharan Africa still bears an excessive share of the global HIV burden. It is estimated 23 million people are infected representing 70% of the world's infection rates (Whiteside & Sunter, 2000) with this region only representing 10% of the world's population. AIDS is the worst infectious disease to hit Africa in recorded history. On a positive note the rate of new infections are decreasing although the actual number of people living with the virus has increased. In 2009, UNAIDS (2010) reported the number had reached 22.5 million, 68% of the global total. Of the estimated 1.8 million people who die from HIV related illnesses 72% of them where in Sub-Saharan Africa (1.3 million). The largest epidemics within this region are Ethiopia, Nigeria Zambia, Zimbabwe and South Africa. A 15-year old in Zambia has a 60% chance of dying from AIDS (Whiteside & Sunter, 2000). According to a population based survey carried out in 2007, South Africa has the largest number of HIV infected people in the world suggesting 5.7 million people were living with the virus. Within South Africa, HIV prevalence rates rose from about 0.5% in 1990 to 27.9% in 2002 (Van Niekerk & Kopelman, 2005). A Department of Health Survey carried out in 2007 based on a sample of 33,488 women attending anti-natal clinics recorded the provinces individual prevalence rates are demonstrated in the table below.

Table 1: HIV prevalence (%) by province 2002-2008

Province	2002	2005	2008
KwaZulu-Natal	11.7	16.5	15.8
Mpumalanga	14.1	15.2	15.4
Free State	14.9	12.6	12.6
North West	10.3	10.9	11.3
Gauteng	14.7	10.8	10.3
Eastern Cape	6.6	8.9	9.0
Limpopo	9.8	8.0	8.8
Northern Cape	8.4	5.4	5.9
Western Cape	10.7	1.9	3.8
National	11.4	10.8	10.9

Brazil had very similar prevalence rates as South Africa initially but followed a very different path with regards to response. As early as 1985 the Brazilian government set up A National AIDS Programme and the AIDS prevention and Support Group. The new constitution written in 1988 gave legal protection to those living with HIV/AIDS from stigma and discrimination and offered access to free health care. In 1991, the first AZT treatment became available and although these early treatment regimes were problematic they were made available immediately. Similarly in early 1996 HAART (highly active antiretroviral therapy) had been introduced as a new treatment, the Ministry of Health in Brazil rolled this therapy by the July making it available to all (Ministry of Health, Brazil, 2001). The government and civil rights groups put pressure on big pharmaceutical companies to make the medication affordable but much of the success was via producing 40% of the drugs locally (Wise, 2006). This was happening back in 1991 before the agreement on Trade Related Aspects of Intellectual Property (TRIPS) was agreed, which protected the patent rights of pharmaceutical companies by limiting generic production and in some cases expanding these time limits. In the early 1990, the World Bank predicted Brazil by the year 2000 would be faced with 1.2 million people infected with HIV. It actually had 600 000. Expanded prevention campaigns

including condom promotion, access to testing facilities, free formula for infants whose mothers are HIV positive, media campaigns, needle exchange programmes and free treatment to all are all part of this HIV/AIDS success story. Sex work is not illegal in Brazil hence a massive campaign aimed specifically at this vulnerable group was rolled out. Why has been Brazil been such a success story?

- A strong relationship between leadership and a will to fight the epidemic;
- Formidable political leadership and a desire to fight the epidemic;
- A liberal, non-judgemental approach to HIV prevention;
- A high priority on condom promotion;
- The provision of free treatment to all and an aggressive effort to minimise the cost of treatment;
- Encouragement for people living with HIV to be actively involved in helping government respond and a commitment to fight stigma and discrimination;

2.4 South Africa

Unfortunately, South Africa could not have taken a more different route. The history of HIV/AIDS within South Africa is arguable the most controversial of any country. It is plagued with illustration after illustration of government's inaction and harmful interference and conflict between the scientific world, HIV/AIDS organisation and politicians. Although back in 1982 the initial concentration of HIV was within the gay community, by the early 1990s, the number of AIDS cases attributed to heterosexual transmission had equalled those due to homosexual transmission. Since then the former has become the dominant route. Unfortunately, by this stage, moralisation of the epidemic had occurred with homosexuals seen as bringing the disease on themselves as opposed to those becoming infected by blood products as innocent victims (Sher, 1989).

Whiteside and Sunter (2000) have suggested secondary to the turbulent political climate, unfounded racial motivation led to conspiracy theories with regards to the spread of HIV. The African National Congress (ANC) whilst in exile alleged HIV could have been developed in a laboratory or spread by the deliberate infection of black sex workers. Others suggested it was spread by the police via tear gas or through the process of desegregating the public toilets (Whiteside & Sunter, 2000). However, this period also saw a more reasonable response to the epidemic with The Fourth International Conference on Health in Southern

Africa producing the Maputo Statement. This document suggested ways to tackle the epidemic concentrating on preventions and the rights of those infected (Haywood & Cornell, 2007). In 1992 there was the creation of the National AIDS Coordination Committee of South Africa (NACOSA) who recognised the need for a broad approach whilst tackling HIV with plans to address prevention, research, human rights, counselling and welfare which brought together a number of government departments.

As the country made its peaceful transition from apartheid to democracy in the early 1990s, the prevalence rates rose from 0.7%-2.2% however it seem South Africa was ready to take on the challenge, ready with information about the disease, ready having seen what had happened in neighbouring countries and Latin America and ready with a group of specialist that could drive the agenda. Regrettably, a number of high profile initiatives in the mid-1990s highlighted the South African government's unhelpful response to the epidemic. European Union money was considered wasted by HIV/AIDS organisations on programmes unplanned, confusing and irrelevant (Nattrass, 2007). Suggested reason why promising action did not materialise varied from devolution of power to provincial government resulting in a lack of a coherent strategy, AIDS not being a priority with so much else going on and government wanting to stay focus on the positives of the future. Once the HIV/AIDS Programme Director had been placed within the Ministry of Health rather than the President's Offices which is what had been set out by the National AIDS Plan, the lack of government support became apparent. It also confined it to being a matter only for the Health Department to consider rather than recognising it as the multifaceted epidemic it is.

The politicization of the science surrounding HIV/AIDS continued to be a major aspect of the South African government's approach towards HIV/AIDS. Access to ARV was denied with President Thabo Mbeki questioning their usefulness and the very theory HIV leads to AIDS (Chigwedere, Seage, Gruskin, Lee & Essex, 2008). Despite research proving the effectiveness of ARV in preventing mother to child transmission (PMTCT), it's use was rejected in all ANC run provinces on grounds of costs despite manufacturers cutting the price and economist believing the use of AZT would be cost saving. Mark Heywood, of the AIDS Law Project said, "Our country cannot afford 50 000 children being born this year and an increase on that number next year and an increase on that number for many years to come" (CNN, 1999).

This denialism continued with the then Health Minister, Manto Tshabalala-Msimang at the 16th Global AIDS Conference in Toronto, presenting a display of garlic, lemons and beetroot promoting herbal medicines to treat HIV rather than ARVs. Mbeki's denialism continued to such a point he accused scientist who stuck to the establish view that HIV causes AIDS as being servants to the pharmaceutical companies and suppressing freedom of speech (Gumede 2008). When Jacob Zuma was appointed President in 2009, it signified the end to state endorsed denialism. Within the first year he gave a speech which acknowledged HIV/AIDS as one of the two most important challenges in South Africa. Although his presidency has been littered with controversies, in 2010 he launch the HIV testing and counselling campaign as part of the process to reach the targets set out by the National Strategic Plan (NSP) One hundred condoms were given for each person tested as well as other prevention initiatives such as information dissemination. The government's latest NSP aim is to ensure 80% of people who need ART have access to them and to drastically reduce the stigma and discrimination relating to HIV (UNAIDS, 2011).

Within South Africa, the United Nation Millennium Development goals have acted as guidelines for the Department of Social Development. For this piece of work the researcher shall focus only on HIV/AIDS, however it is recognised that malaria and other diseases are also of high priority. Without the reduction in prevalence rate, this disease has the potential to hinder all other sustainable social development secondary to slowing the national economy. Economic growth is necessary for a nation's development as it creates wealth, which in turn creates job opportunities. Consequently, more people are able to pay taxes therefore providing the government with more revenue to re-invest back into social services such as a country's health care system, education and welfare system. It took some time for the professional economists, central banks and governments to fully appreciate the impact HIV/AIDS would have on an economy as the traditional assessment models used could not reflect "a very large scale wave event" (Barnett & Whiteside, 2005).

By 2000 some comprehensive studies were emerging which talked of anything between a GDP fall of 1% per year to being 13% lower after 25 years of the virus eroding the economy (Barnett & Whiteside, 2005). This could result in economies being 24-38% smaller according to the Investment Banking Barings which to most people sounds alarming enough but put into real terms represents a reduction in real household income and real disposable income, affecting domestic spending/saving, trading, employment and once again government

spending. To summarize, HIV/AIDS will have a devastating effect on the national economy which in turn will have an impact on business.

2.5 The world of business and HIV/AIDS

“Business not only has a responsibility to act, but an opportunity to play a crucial role in the global fight against the HIV/AIDS epidemic, particularly in their own workplace. Company leadership in distributing condoms, providing voluntary counselling and testing, and access to care and treatment send a strong message to other sectors” Richard C. Holbrooke, President & CEO, Global Business Coalition on HIV/AIDS (2009).

The Business community is in a unique position to make a difference in facing up to the epidemic of HIV/AIDS, by developing workplace programmes. Despite the documented effects HIV/AIDS may have on the economy, business is still greatly underestimating the impact of the virus (South African Business Coalition on HIV & AIDS, SABCOHA, 2006).

Whilst considering HIV/AIDS in the workplace and why South Africa has been unsuccessful in incorporating business in its strategic mitigation plan perhaps we can look further a field at one of the few success stories to highlight why South Africa has such a huge problem now. Uganda, back in 1990 responded promptly to HIV by taking a multi-sectoral response and recognised HIV/AIDS not just a medical concern but a concern for all sectors of society. With full presidential backing, involvement from all governmental ministries, non-government organisations both national and international, major international agencies and even religious ministries a strong Ugandan AIDS Commission was set up and although not all of the goals were met it opened up the platform for discussion and debate. Not until the year 2000 did South Africa organise an equivalent a whopping ten years later, releasing a new National HIV and AIDS/STI Strategic Plan with the aim of improving multi- sectoral participation with a philosophy of inclusion of all to tackle this virus head on. The Southern African Development Community (SADC) (August 2000) endorsed the redistribution of accountability for all aspects of HIV/AIDS across all social and economic sectors. Generally it was acknowledged to build capacities to respond to the epidemic, all sectors of society need to be involved. Despite this recognition the business community has been slow to do so when it really needs to be at the fore front of planning for the impact of HIV/AIDS. The focus of this study is specifically at small business and even more specifically, within the construction industry.

According to Dr Bakuwa (2003) the lack of empirical research within Sub-Saharan African on what companies are actually doing to address HIV/AIDS in the workplace is a concern. She believes there is much information on what action can be taken and many examples of best practices but few academic studies have concentrated on assessing directly what action business is taking. Although her work is based in Malawi, Bakuwa believes there are many similarities between South Africa and Malawi. Malawi is part of Sub-Saharan Africa that is grappling with HIV and has followed a similar demographic pattern to South Africa, which has been one of showing a rapidly escalating epidemic (Government of Malawi, 2003). Like South Africa, latest statistics indicate adult prevalence rates have gone down slightly suggesting a degree of progress however this small triumph is battling to be positive against an increase in the actual number of people being infected secondary to population increase. Bakuwa recognises that within Malawi, the HIV/AIDS epidemic has numerous workplace implications due to its disproportionate effect on the most productive section of society i.e. those aged 15-49.

The repercussions of this are felt both at a macro level such as markets, investments, services and education and on a micro level of greater absenteeism, high turnover and reduced productivity. This reflects a similar picture within South Africa. Bakuwa is of the opinion the world of work is an ideal setting to tackle HIV/AIDS. In her study of 162 randomly selected Malawian companies, conducted in 2010 she found the three major factors hindering the adoption of HIV/AIDS workplace policies by private companies were that HIV/AIDS is not a priority business issue, there is no visible HIV/AIDS impact on the operations of the company and there is no staff participation in the activities of HIV/AIDS institution.

The least significant factor hindering adoption was the lack of financial resources. Bakuwa further comments it has to be seen as effecting productivity and profit otherwise HIV/AIDS will not be perceived as a threat.

The view expressed by Rau (2002) states that despite the “compelling humanitarian and ethical arguments” for companies to take action, it is only the business case which will persuade business to invest in HIV/AIDS workplace policies. Rosen, Maclean, Vincent, Thea, & Simon (2004) suggest daily problems such as power failures, unpredictable taxes and political instability which can be regular occurrences within Africa directly affect business where as the very hidden nature of HIV makes it almost impossible to be regarded

as a priority. Singhal and Rogers (cited in Bakuwa, 2010) also point out the advantages of preventing an employee from becoming infected is very difficult to measure hence companies will not take action as they cannot see the effects directly.

It would also appear lack of top management support is another main stumbling block however, as Bloom, Bloom, Stevens and Weston (2004) point out, the challenge of the HIV/AIDS problem is so enormous that successful intervention should not be embarked upon alone. In reality, as Rau (2002) suggests, companies infrequently run HIV/AIDS programmes in isolation but rely on private-private and public-private partnerships. Again, these findings collaborate with the results of other countries like Uganda, who have taken a multi-sectoral approach. However they have also had good strong leadership with clear strategies, which in the opinion of the researcher is not the case within South Africa at present.

Phororo (2003) a researcher at the Namibian Economic Research Unit with an interest in research on HIV/AIDS and its impact on the private sector and households, suggests while considering the Global realities of a world with HIV/AIDS one should reflect upon life expectancy. She highlights, according to the US Bureau of Census (2010), countries most affected by HIV/AIDS could lose up to 31 years of life which is a devastating reality.

Table 2: Estimated Life Expectancy, 2010

	Without AIDS	With Aids
Botswana	66.3	37.8
Cote d'Ivoire	61.8	46.7
Kenya	69.2	43.7
Namibia	70.1	38.9
South Africa	68.2	48.0
Zambia	60.1	37.8
Zimbabwe	69.5	38.8
Brazil	75.5	67.7
Honduras	73.4	59.7
Thailand	75.1	72.9

She concurs with a great deal of other research on the effects of HIV/AIDS on the economy, suggesting it should be a major concern to companies. Her expressed view is it weakens economies by reducing productivity, adding costs, diverting productive resources and eroding the skills base. While contemplating the latter it is sometimes intimated it is easy to replace a low skilled labour workforce, which although completely inhumane may well be a reality. However, she implies even with low skilled labour, a company will still incur replacement costs as it takes time to train and gain the confidence in the new worker.

She also discusses the effect on productivity in terms of increased absenteeism, organisational disruption, loss of skill and organisational memory, rising staff turnover and loss of skills and elaborates to consider invisible costs such as decreasing morale and loss of institutional memory. UNAIDS (2002) estimated that the combined impact of AIDS related absenteeism, productivity decline, health care expenditures and recruitment and training expenses could cut profits by at least 6-8%. Research in Kenya revealed as much as a 20% loss of profits where as comprehensive prevention programmes were likely to cost 2% therefore making sense for business to be pro-active rather than re-active. She discusses how some of the bigger businesses have recognised the potential devastation HIV/AIDS could have on their profits and steps which have been taken such as the training of peer educators and clinics on sites but she suggests considerable more still need to be done. What this researcher finds interesting is her discussion around small business which concurs with Bakuwa, is the opinion that small business tends not to be active in the fight against HIV/AIDS. Very similar reasons are put forward i.e. business underestimating the impact of HIV/AIDS, there is no cohesive response and lack of resources.

Interestingly, Phororo (2003) also deliberates on small, labour intensive companies who operate in the informal sector. This researcher believes the recommendation for companies to endorse peer educators, VCT, health care and funeral expenses is completely unrealistic for the majority of small or even micro businesses. Yet these businesses employ far more people than the public or formal sector and play an important role in economies (Phororo, 2003). In Namibia, small business employ close to 160 000 people which represents a third of the nation's workforce with the vast majority employing 1-20 persons. Small business cannot be ignored. Incomes are generally low with very little capital available. If an owner dies, the implications are serious for the dependents meaning HIV/AIDS may worsen poverty. An assessment carried out by Phororo and Mohamed (2001) on the private sectors response

revealed 57% of these companies had not responded to the impact of HIV/AIDS. The reasons were very similar to Bakuwa (see Appendix 1) with additional reasons being, companies were newly established, condoms could be readily sourced from Ministry of Health and Social Services, HIV/AIDS a sensitive issue, staffs' sexual behaviour is a personal issue and current HIV/AIDS initiatives were inadequate. She suggests ways small business in Namibia can become more active, firstly by the establishment of a Namibia Business Coalition on HIV/AIDS, secondly the establishment of sector specific groupings and thirdly by incorporating small business into existing HIV/AIDS programmes. The researcher believes whilst this is all very positive it is too top heavy and still does not recognise the very informal often struggling nature of small business. Within this piece of research, the researcher would like to develop recommendations which are far more grassroots orientated and practical. The researcher also feels there should be incentives for small companies to get involved.

Whilst considering SME business research such as that carried out by Ebony Consulting International 2002, suggests, "HIV/AIDS does appear to be having a negative impact on many SMEs, increasing both direct and indirect costs. Many firms are responding, or trying to respond, but it is difficult for a small business to develop and implement an effective programme" (Fraser, Grant, Mwanza & Naidoo, 2003). Connelly and Rosen (2005) carried out a study addressing the lack of response from small to medium size business to acquire an understanding of why this was the case. They concluded that current demand for HIV/AIDS services among small to medium size business in South Africa is minimal. Consistent reasons are: lack of information and access to services, stigma and lack of pressure to act. Connelly and Rosen suggest an information campaign directed at small to medium size business to increase demand for lower-cost services and the use of business and employee association such as the chambers of commerce, trade groups and labour unions. Governments and donor agencies need to understand the differences between SMEs to help the funding of programmes more effectively. An industry-specific campaign which is tailored to accommodate both large and small businesses needs to be developed to give the information needed to address this gap.

Bakuwa's 2010 research highlighted the third ranked factor hindering the adoption of HIV/AIDS workplace policies was no staff participation in the activities of HIV/AIDS institutions. Within the context of her study, staff participation in the activities of HIV/AIDS

institutions implies company staff would be involved in awareness activities, meetings or workshops organised by HIV/AIDS institutions. Swan and Newell (1995) have suggested that before a company can adopt a workplace policy it needs to acquire knowledge about these new policies or practices so it can consider what is relevant to their needs. Therefore, the employees of a company need to be aware of the development of a HIV/AIDS workplace policy and the more involved the employees are with outside organisations, the more relevant their input will be. It therefore follows that no staff participation in the activities of HIV/AIDS institutions within Bakuwa's study, was one of the major stumbling blocks hindering the adoption of HIV/AIDS workplace policies. Within this study there was a significant relationship between the state of HIV/AIDS workplace policy and staff participation in the activities of HIV/AIDS institutions. Companies whose staffs were not participating in HIV/AIDS activities were unlikely to demand the adoption of workplace policies.

2.6 Previous research on HIV/AIDS workplace policies

Whilst considering previous studies on HIV/AIDS workplace policies, the Bureau for Economic Research (BER) conducted a survey on behalf of the South African Business Coalition on HIV/AIDS (SABCOHA) contemplating the impact of HIV/AIDS on selected business sectors. This survey took place between the 15 July and 6 September 2004 in which 1 008 companies participated in the survey. Eight sectors were considered including the mining, manufacturing, retail, wholesale, motor trade, building and construction and the financial services sector. The survey results demonstrated the mining sector is the worst affected followed by the manufacturing sector. The size of the company also has a bearing on the results as does which province it is based in. A significant percentage of companies with less than 100 employees have not observed HIV/AIDS related impact. Likewise, companies based in the Western Cape have not felt the impact in comparison to KwaZulu-Natal and Gauteng, the two provinces with some of the highest HIV prevalence rates. Whilst the survey emphasized 77% of mines, 58% of the financial sector and 50% of manufacturing companies have an HIV/AIDS policy in place it also highlighted less than a third of the other sectors had implemented a policy. Chief Executive Officer of SABCOHA, Brad Mears, commented how disturbing the lethargic response by certain sectors is which included the construction industry. As the third most vulnerable sector after mining and transport, this lack of response remains a real challenge.

An explanation for this could be firstly assessing the impact of HIV/AIDS within the business is a complex issue. Although it may seem possible to use a quantitative approach for calculating the costs such as increased health expenses, lower productivity, absenteeism, death, disability and higher employee turnover hence increased training cost. Barrett, (2004) reports accounting for the psychological impact such as low morale is beyond such approaches. Therefore, even companies whom invest significant energy and recourses into understanding the specific business impact, find it difficult to measure and estimate the actual cost hence companies can remain unaware and therefore tend not to develop a strategic response (Bloom et al., 2005).

Rosen et al. (2004) suggest the visible impact of HIV/AIDS on a company may become obscured for several reasons such as: Due to the long incubation period of HIV and since AIDS involves a comprised immune system, often employees will present with opportunistic infection which are often recorded on their death certificate rather than HIV. Secondly, social factors may also obscure visibility such as the stigma associated with HIV hence employees may not identify themselves as such with many of them not even knowing they are HIV positive (Dickenson & Stevens, 2005). Therefore, the stigma associated with the disease may mean an employee may go to great lengths to hide this from his employer or avoid testing to remain ignorant of it (Rosen et al., 2004). As a result of these factors, the impact of HIV/AIDS within a company may not be very apparent and therefore not receive the attention it requires. This lack of recognition implies some companies may not consider themselves as vulnerable with regards to the epidemic and may therefore not comprehend the need for any action to be taken to address HIV/AIDS in their workplace.

This may well be secondary to the stigma associated with the disease and the prevailing silence that surround it. Breaking this silence around the virus is essential with Dr Peter Piot, UNAIDS executive director suggesting, “It is unfortunate we are still hampered by our old enemy: stigma. Eliminating stigma must be central. It is about breaking silence and breaking silence means breaking secrecy, not confidentiality, about AIDS.” (UNAIDS, 2011).

Being resource limited according to results from Bukuwa’s research is not ranked as a significant hindering factor for companies that had not yet adopted HIV/AIDS workplace policies. In reality, some studies have shown that availability of financial resources for a particular course of action or programme goes simultaneously with the commitment from top

management (Kamuzora, 2006). If the top management lacks committee then the appropriate funds are unlikely to be made available. In many organisations, top management has control over financial resources and therefore their commitment is essential. A strong top management will make it clear that addressing HIV/AIDS is a company priority and will allocate the funds needed to develop HIV/AIDS workplace policies.

The World Bank (2000) recognised strong political commitment facilitates the provision of required resources which is vital in order to address HIV/AIDS. This could suggest, on a company level, strong top management support makes possible the provision of the necessary funds as well as creating the right environment to address HIV/AIDS in the workplace. Failure to do so in Bukuwas' research demonstrates finances are not a major stumbling block for companies failing to adopt HIV/AIDS workplace policies but top management's lack of support is. In those companies, top management have not committed financial provisions to address HIV/AIDS in the workplace secondary to managers not understanding the dynamics underlying the adoption or non-adoption of policies to address the particular issues facing their individual companies. These findings are of particular importance to developing countries as lack of resources would more often than not be a justifiable reason for a lack of action. While the findings of Rantanen (2004) and Kamuzora (2006) acknowledge that many developing countries do not have abundant resources but suggest action on occupational health and safety issues is not merely dependent on the availability of funding but also on awareness and priority. Kamuzora's (2006) view is the underfunding of occupational health and safety programmes is a lack of political will rather than financial resources per se. The money is there but the problem lies with its release for appropriate use. Therefore, lack of finances may not be a justifiable reason for a lack of action to address HIV/AIDS.

This is not surprising findings, it only confirms the literature which has established the construction industry's slow response in implementing general workplace programmes, especially treatment programmes. A study carried out by SABCOHA (2005) reported only 3% of construction companies provided ART. Various open-ended responses for not having a treatment programme include: don't know what it would cost or what would be involved but the recession makes it hard to justify; no HIV-risk; business far too small; too small-not effected; yes, if there were people with HIV we would run a HIV programme but we don't; business too small, we would have to rely on the state to assist us of NGOs. One respondent commented they would like to know more about time/cost with another suggesting they have

not considered the associated costs of treatment programmes. Whilst considering treatment programmes, companies require information on the benefits of investing in treatment and care with Setswe (2009) demonstrating through a company risk assessment, providing ART has significant advantages over not.

However, The Department of Public Works (2004) has responded to the threat of HIV/AIDS to the construction industry by developing a strategy to mitigate these effects. Within the Strategy, the Department of Public Works (DPW) specifically aims to:

- Reduce the rate of new HIV infections in the industry
- Ensure appropriate management of construction workers affected and infected by HIV/AIDS
- Facilitate access to Voluntary Counselling and Testing (VCT)
- Facilitate access to Sexually Transmitted Infection (STI) treatment
- Capacitate the industry with the necessary knowledge on treatment, self-care and wellness for the HIV infected
- Reduce the stigma and discrimination attached to construction workers suffering from HIV/AIDS
- Encourage safe working environment on construction sites
- Position the industry to respond to the risks of direct and indirect costs incurred as a result of the disease
- Aim to reduce HIV/AIDS infection in the communities in which the industry works
- Monitor, evaluate and review the strategy continuously to ensure relevancy and effectiveness

All DPW contracts exceeding R2 million are required to implement an HIV/AIDS awareness programme on site. Contractors will have to provide awareness workshops to all those who are based on site for more than thirty days. These workshops will take no longer than 2½ hours and can cater for twenty five people. A video can be obtained from DPW along with awareness materials and condoms. The DPW estimates for a contract valued at R3 million, the HIV/AIDS approximate total cost would be R3, 865.41 therefore =0.12% of the total contract value. As custodians of the industry, the DPW recognises it has a social responsibility towards the industry, concentrating on the immediate impact as well as

considering the future impact of HIV/AIDS. The DPW has recognised it is faced with increasing HIV prevalence amongst its workforce and has responded with an urgent strategy.

Within the DPW HIV/AIDS Awareness Programme Training Manual for tenders within the construction industry, there is a step by step guide on exactly what, why and how a contractor needs to put into practice a workplace policy as part of the tendering process. This cannot be negotiated. It is a twenty page document which gives a background to the enormous concern HIV/AIDS poses within South Africa and how it concerns the construction industry workforce and clearly sets out the HIV/AIDS strategy for the industry. It details principles of the HIV/AIDS Awareness Programme including where to acquire them (posters, videos, condoms) and most importantly cost, highlighting that most of it is for free. There are workshop plans with checklists on the training requirements with advice on how to identify an approved trainer. A list of support services are provided for training service providers, awareness materials, condom dispensers, condoms, lists of local clinics and closest VCT facilities. This manual then proceeds to quantify the cost of the programme breaking it down to exact details. It provides case studies as example of good company policy and how the company can prepare for the implementation of a given policy. In this instance, government appears to be fully supportive in not only the recognition of the problem but a comprehensive strategic plan to tackle it.

However, within this manual, the DPW identifies its need to champion the cause but also emphasis there are no legal requirements to force business to implement programmes focusing on minimising the impact of HIV/AIDS. Therefore, unless a company is tendering for a Public Works Contract of over R2 million, there is no reason/incentive to consider HIV/AIDS, which is reflected in this researchers results, Professor Paul Bowen's work, BER finding and a great deal of other research.

Within the construction industry, there are already bodies who keep a register of companies, for example the National Home Builders Registration Council (NHBRC). This is a regulatory body whose goal is to assist and protect housing consumers against poor workmanship. This body advocates consumers should only use a builder who is registered and certified by the NHBRC, to ensure that the home is not exposed to structural failure. The NHBRC was established in 1998, in accordance with the provision of The Housing Protection Measuring Act, and requires by law any person in the business of building homes,

to be a registered member. Any new build or housing alteration project requiring a bank loan has to go through a NHBRC registered company. Adding a requirement of a HIV/AIDS policy the equivalent to the Department of Public Works HIV/AIDS Awareness Programme, could be initiated and even supported by the NHBRC by having an advisor on board to assist. Bukuwa's (2010) findings simple indicated HIV/AIDS was just not a business priority as business could see no visible impact. This factor has also been demonstrated within this researcher's small survey. The researcher is going to discuss both findings and possible solutions to the concern.

HIV/AIDS is not a priority business issue. If HIV/AIDS is not defined by top management as a priority business issue they are not prepared to put the necessary resources in place to support it. Rosen, Freeley, Connelly & Simon (2006) considered one way that might determine the priority businesses give to HIV/AIDS workplace management may be by measuring its significance. Does management consider HIV/AIDS a problem within the company? If it is not regarded as a significant problem, then it may not be considered a priority business issue therefore the companies' decision makers will not feel compelled to take any action. Rosen et al (2006) found a statistically significant relationship between the state of HIV/AIDS workplace policy in a company and the perceived priority of HIV/AIDS as a business concern. In this study it meant there were considerable variations in the adoption of HIV/AIDS workplace policies based on the perceived priority of HIV/AIDS as a business issue. It follows therefore, those businesses that did not perceive HIV/AIDS as a business priority were unlikely to adopt HIV/AIDS workplace policies.

In the study by Bukuwa (2010), the majority of companies were yet to adopt policies to address HIV/AIDS in their workplaces because it was not perceived as being a priority business issue. This would collaborate with other findings which suggest population wide infection rates do not act as sufficient evidence of a business risk that should prompt them to take action (Ellis & Terwin, 2003; Rosen et al., 2004). South Africa has a high prevalence rate but despite this, evidence would suggest this is not enough for business to consider it a significant risk.

An explanation for this could be, businesses operating in developing countries like Africa face a multitude of problems ranging from power failures, high and unpredictable taxes to political insatiability hence HIV/AIDS is not considered a priority concern (Rosen et al.,

2004) The Government of Malawi (2002) suggests many companies face more immediate survival concerns hence the long-term threat of HIV/AIDS might easily be underestimated because of the very hidden nature of the virus. There are also the very real problem of demonstrating HIV/AIDS workplace programme has benefitted a company as the fact an employee has not contracted the virus is an immeasurable advantage (Singhal & Rogers, 2003). Rosen et al (2006) suggests the extensive time between preventative costs which are immediate and the benefits which will only be appreciated years later, makes it difficult to capture the financial benefits of investment in HIV/AIDS workplace programmes.

Another possible explanation why business has not rated HIV/AIDS as a major concern could be the employees themselves do not consider it a priority (Feeley III, Rosen & Connelly, 2008). There are more immediate concerns over wage levels, job security and pension which are of a higher priority to the workers. Unions could well be in an advantageous bargaining position to make HIV/AIDS a major business issue but some studies have highlighted their members do not rate the issue highly and therefore it has not become a high priority union issue. The stigma and discrimination associated with the virus may also be a barrier to opening up the discussion of HIV/AIDS within the union environment.

It would appear there are a multitude of barriers facing companies operating within Africa whilst considering HIV/AIDS workplace policies. Demonstrating the advantages of action on HIV/AIDS and the inability of trade unions to make it priority concern may lead companies to ignoring the significance it will eventually have on the human resources their survival depends upon.

3. Research methodology

3.1 Research design

The research design that was used will be descriptive as the aim is to describe certain characteristics of a specific group, estimate the proportion of people who behave in a certain way and make recommendations.

The following research method was employed:

1. A review of relevant literature of the impact HIV/AIDS on the construction industry.
2. A review of the relevant literature of the response to HIV/AIDS of the construction industry.

3. A questionnaire survey of small businesses within the construction industry on their perception of HIV/AIDS as a danger to the industry, and their workplace responses.
4. Case study of how HIV/AIDS may be affecting a small company within the construction industry.
5. An analysis of the findings, recommendations and a conclusion.

3.2 Research question

The research questions to be focused on are:

- a. What are the perceptions of HIV/AIDS as a threat to small businesses within the construction industry?
- b. What is the involvement of small businesses within the construction industry to HIV/AIDS within the Western Cape?
- c. What are the barriers for small business within the construction industry for implementing HIV/AIDS workplace policies?

3.3 Data collection

A survey was conducted by using a self-administrated questionnaire consisting of both closed-ended questions, open-ended questions, declarative and multiple choice questions. For indicators of importance the five-point Likert scale has been used. The questionnaire will be divided into four parts, with (A) seeking demographic details, (B) considering company perception and policy, (C) the relationship between HIV/AIDS and employees and (D) assessing company involvement and HIV/AIDS. The questionnaire was distributed to top managers and CEOs of small construction companies within the Southern Suburbs of the Western Cape.

3.4. Population and sampling

Whilst considering survey methodology, sampling is widely used for gathering information about a population (Brandburn & Sudman, 1988). A population can be considered as items or people with the characteristics the researcher wishes to understand (Castello, 2009). For many reasons such as time or money, researchers are unable to gather information from everyone or everything in the population hence a representative sample of that population is sourced. In this instance the common denominators were small companies within the construction industry, based in the Southern Suburbs of the Western Cape.

There are many different types of sampling frames however probability sampling such as simple random sampling, systematic, cluster or multi stage sampling were not considered appropriate due to the sensitivity of the subject (McGreevey et al., 2003). Hence a non-probability purposive sampling method was implemented as it targets a particular group of an atypical population. The intention of this sampling process was to highlight small possible informal building companies and their attitudes towards implementing HIV/AIDS workplace policies.

The researcher took names of companies from several locations, firstly from the local community directory “The Blue Book”. This has a construction section in it with names and contact details of local building companies. The intention was to start with a local directory and if the numbers were not enough to then look at the National Home Builders Registration Council (NHBRC) for additional companies. The researcher’s intention was to randomly select sixty companies, send them the questionnaires with the expectation of receiving thirty back. However, this method did not work out and will be discussed later.

3.5 Data analysis

The researcher intended to use the Statistically Programme for Social Science (SPSS) for the data analysis. However, as the completed questionnaire numbers remained low, Excel was deemed more appropriate.

3.6 Ethical considerations

Ethical consideration involved in research is an integral part of the research proposal and

to the conduct of research (Sieber & Stanley, 1988 cited in Christensen, 2011). In research cases of a sensitive nature, such as domestic violence or child abuse, it may be difficult to investigate without violating the individual's right but the information is necessary to fill a knowledge gap. Hence an ethical dilemma is created. To avoid any ethical concerns the researcher proposed the data collection to be strictly on a voluntary nature and be confidential. All those who participated were guaranteed anonymity as they were not required to put any names or ID on the questionnaire. There will be no way of tracing the information back to the individual. Only the consent form will contained their names. The researcher will keep all the information collected locked away. The researcher also submitted her proposed study to the research ethics committee at Stellenbosch University who gave permission for the study to proceed.

4. Data analysis and interpretation

This shall be discussed under the four different research questionnaire headings.

4.1 Section A: Demographic profile of respondents

Of those who completed the questionnaire 80% indicated to be in senior positions either CEOs, owners, company directors or commercial managers. The other 20% did not answer this question. All the respondents employed less than fifty permanent staff members with 71% employing less than ten employees. Companies' employment of non-permanent staff found 62% employed less than five, with 31% employing between five and twenty over any three month period. The entire sample surveyed had an annual turnover of under R6 million, specifically 23% under R750 000, 46% between R750 000-R3 million and 31% between R3-6 million.

4.2 Section B: Perception of HIV/AIDS as a long term problem and the presence of HIV/AIDS company policies

Using a five point Likert Scale (1= not a problem; 5=significant problem), respondents were asked to rate how they perceived HIV/AIDS as a threat to the construction industry. A majority of 64% perceived it as at least a problem with 37% responding they perceived HIV/AIDS neutrally or only a slight problem. Interestingly, a similar study carried out by Bowen (2007) found only 53% of respondents perceived HIV/AIDS as a long term threat

to the construction industry with this sample having an annual turnover in excess of R26 million and thus categorised as large (Statistics South Africa, 2008). However, despite the researcher's majority finding of small companies' perception of HIV/AIDS as a problem only 17% replied they had a policy. These findings differ from those of the BER (2005) whose results suggested just under a third of construction firms surveyed had implemented an HIV/AIDS policy. Of the 17% who do have a policy, 50% have an awareness campaign, 25% a prevention programme and 25% replied their policy involved offering treatment.

For the 83% of small building companies whom do not have a policy, 63% replied they saw no visible HIV/AIDS impact on the operation of the company, 9% do not consider it a workplace concern, 9% lack financial resources, 9% saw no visible staff participation in activities surrounding HIV/AIDS and 9% felt their staff's sexual behaviour to be a personnel issue. These findings concur with the general observations of Ellis and Terwin (2003) that have suggested whilst the presence of a mitigation policy in construction organisations indicates stronger acknowledgement of the impact of HIV/AIDS, larger firms are no more likely than smaller ones to develop a policy.

With regards to prevention, 92% did not have a programme with the rationale behind not implementing one very much reflecting that of lack of an awareness programme i.e. no need, no risk, not a problem, company not big enough but with one interesting comment asking "how"? The researcher will consider this later. With regards to treatment programmes, 92% of companies did not have a programme and again, when questioned why, they gave similar responses to those above; "none of the staff are HIV positive" "no risk", "no need" "company has not yet felt the effect of HIV" etc.

For the 83% of small building firms whom do not have a policy, 63% replied they saw no visible HIV/AIDS impact on the operation of the company. No visible impact on the company was the highest ranked factor hindering the adoption of HIV/AIDS workplace policies. This lack of disclosure was evident in this researchers finding as 55% of all respondents felt HIV/AIDS did not affect them as a company as no staff were infected. Within this particular research, only 9% considered no staff participation in activities of HIV/AIDS institution of consequence to the implementation of a workplace policy hence

favours Swan and Newell (1995) suggestion. Around 9% of those who completed the survey commented staffs' sexual behaviour was their own issue.

4.3 Section C: HIV/AIDS and employees

It has been well documented and discussed with this piece how important top management's support is whilst considering HIV/AIDS as a workplace concern. In this study 92% did not encourage their employees to know their status. The question which followed asked the manager to estimate the percentage of their employees who are HIV positive. The results are shown in the table below.

Table 3

Percentage of assumed HIV positive employees; % Respondents	
None	76.92%
1-5%	0.0%
6-10%	7.6%
11-15%	0.0%
16-20%	0.0%
21-15%	0.0%
25-30%	0.0%
31-35%	0.0%
36%-40%	0.0%
41-45%	0.0%
45-50%	0.0%
Do not know	15.38%

As illustrated in Table 3, a large majority (77%) of those surveyed did not feel any of their employees where HIV positive. With a prevalence rate of an estimated 13% within the Western Cape (Statistics South Africa, 2007) and industry specific rates being considered as 25%, the researcher can only conclude employees are not disclosing their status or they simple do not know. This is in keeping with the findings that 92% of employers interviewed did not encourage their employees to know their status. The

advantages of an employee to disclose his status, such as being able to take medication at work, flexible working hours and time allowed for attend clinics may be far outweighed by the fear of being discriminated against if the employee were to know. Disclosure of one's HIV status is an essential part of behaviour modification, access to HIV treatment and for decreasing community and workplace stigma (Ncama, 2007).

4.4 Section D: Company involvement & HIV/AIDS

Within this section those surveyed were asked to consider the financial viability of running an HIV/AIDS treatment programme. Not one of the respondents felt it was financially viable for their organisation to have an HIV/AIDS treatment programme. However 45% said they did not know if it was financially viable. One of the least significant factors hindering the adoption of an HIV/AIDS workplace policy was lack of financial resources. Whilst considering small businesses, the role of available finances should not be underestimated with evidence from literature highlighting that a lack of resources would make it difficult to address HIV/AIDS in the workplace (Rosen et al, 2006).

5. Challenges of this research

The researcher shall now consider the barriers and difficulties encountered whilst carrying out this research.

5.1 Data collection

Within this section the researcher's original intention were to source local building companies, firstly via a local business directory, "The Blue Book" and secondly via the NHBRC. With most companies having websites and email addresses it was assumed this line of communication could be used. Here, one of the first major obstacles was encountered. Having sorted a number of appropriate companies the researcher sent a very brief introductory email explaining her background and reason for the research along with an attachment, which was the questionnaire. The researcher phoned three CEOs who said they would complete the questionnaire via email. Unfortunately not one questionnaire came back completed. The next step was to resend them and wait. No response once again. A few phone calls later and it becomes apparent people's good intention

materialized into nothing. Having considered why this might have been Foddy (1994) suggests sending the email on a Friday will obtain better results and suggests there is usually a reply rate of 50-75%. The researcher made the questionnaire an attachment rather than part of the email which was perhaps a mistake as Foddy suggest attachments will not be opened. A few weeks went by with no response. It was at this point the researcher decided a change in tactic was needed hence the researcher cleared her week and physically went round the local area looking for building sites and approached the foreman/CEO/managers on the actual sites.

5.2 New approach to sampling

There are three new security estates within the Noordhoek Valley area within Cape Town which have many plots being developed hence the researcher and an assistant spent the week approaching these sites. This turned out to be far more productive although site managers were at first reluctant to take time out, once the researcher had persuaded them, they were very happy to talk. Confidentiality was extremely important hence once they signed the consent form it was physically shown to be put in a box with all the other forms hence the questionnaire was completely anonymous. This was incredibly important and once the researcher had completed a few felt it was necessary to communicate this as soon as she had introduced herself. Interestingly, the questionnaires did not consider race but the researcher noted the two black foreman approached did not have time to fill in the questionnaire. Such is the stigma associated with this virus.

The researcher decided the site managers should fill in the questionnaire themselves which would give them more comfort the researcher would not remember what they filled in-hence once again assuring confidentiality. The researcher advised they should only complete the questions they are happy to fill in. One question that caused a little unease was the one asking what the company's annual turnover is-with several companies leaving that question blank. The researcher reassured them this was fine as she appreciated their time recognising how precious it is.

The majority of the site managers were reluctant at first to take time out to fill in the questionnaire but interestingly, once into it had numerous questions and a great deal to say about the issue. Most were shocked to hear a prevalence rate within the industry of

22.1% with death rates depicted as 2.1 per 100 workers (George, 2006). Most assured me their workers were HIV free although as discussions progressed some became a little doubtful. Informing them of the progress in ART and that HIV no longer meant a death sentence-more of a chronic illness was news to most of the site managers as was the fact that ART was free.

One site manager, after a lengthy discussion, decided he would encourage his men to get tested but that the clinic was only open when they were at work. He could not give them time off work to go to the clinic. He had about fifteen men on site hence the researcher suggested two men go at a time (if they want to) in the morning and come to work afterwards. They should bring a note from the clinic to prove they have been but under no circumstances feel under pressure to disclose their status. He thought this was a good idea.

Overall, whilst talking to these site managers, there appeared no malice in not having a workplace policy, just ignorance. Many felt they are just not big enough to concern themselves with complicated workplace policies or just did not know how. Harry Lake from Care Works feel the construction is just too fragmented to be tackled but this researcher believes if it is assisted from a comprehensive strategy, it can be done.

6. A case study of how HIV/AIDS may be affecting a company

The researcher believes a case study demonstrating how HIV/AIDS may be affecting small businesses within the construction industry would at this point be of value. Research, including this researcher, has demonstrated the construction industry is not responding to HIV/AIDS in the workplace. Of those interviewed for this study only 17% had a HIV/AIDS workplace policy with only 50% of these having awareness and prevention programme and only 8.34% have a treatment campaign. Having considered this, the researcher gained the permission of one company to actually calculate if there was any measurable impact on the company.

The impact of HIV/AIDS on business will primarily be an increase in operational costs. Providing health care will become increasingly costly as employees become sicker, death benefits will escalate, whilst the replacement and training costs of sick or dead employees

will also proliferate. Simultaneously, productivity will be decreased and absenteeism increased resulting in a reduction in company revenue. These are all fairly quantifiable operational consequences of HIV/AIDS however just as importantly but less easy to enumerate is the impact on morale and a working environment filled with suspicion, tension and a loss of hope (Du Toit, 2010). This can be alleviated by business being proactive by discussing HIV/AIDS issues to reduce the stigma related to it and guarantee workers remain industrious.

The researcher shall now utilize the AIDS Impact Model for Business (AIM-B model), which is a model designed to help human resource managers assess the effects of HIV/AIDS on a particular section of the workplace. Those using the model could input data from an entire workforce within a particular country; although the differences in wage levels, benefits and recruitment costs would be so varied the task would be a difficult task. Therefore, considering different sectors of the workplace may be more beneficial, such as managers, skilled workers or unskilled workers. With this in mind the researcher has decided to use the model on the semi-skilled/unskilled workers with the company and not those of skilled-top management level. Step one of the process is information gathering, how many employees in the company may be infected with HIV? What are the recruitment costs, the training costs and the cost to the employer when an employee dies and increased health care expenditure per individual employee who is positive? Whilst using the AIM-B Impact model it is best to have all this information to hand before connecting to the internet so you can access the results immediately.

How many of your employees may be infected with the HIV/AIDS virus?

Within this section, the model requests an estimation of the percentage of those within a specific workforce section whom are likely to be infected with HIV? Unfortunately, there is no industry specific research available (Meintjes, Bowen & Root, 2007) but within the model you can use countries general prevalence rate. Therefore, the researcher shall use this percentage rate although it is based on UNAIDS estimates from 1999, which is not the most up to date however, it is specific to the age group 14-49, which the researcher knows is applicable within this company. Also, within the company, there is no data to indicate prevalence rate, the CEO is unaware of any HIV positive employees, in fact suggesting there are not any so this is the option of preference.

Average Salary

The average annual salary of the workers in this chosen group was a much easier task as there are records, albeit sometimes informal, available hence the CEO and the researcher managed to work calculate an average for the last six months.

Recruitment costs

This was much harder to estimate as the company lacks any formal Human Resource Manager hence it is somewhat of a speculation. There are no advertising costs as such as it is all word of mouth and consequently no agency fees. However, the CEO and his administration personnel do spend time sorting new contracts, UIF and tax administration which can be considered a cost. There is also time spent talking to potential employees which, when considered on a weekly basis, was a substantial amount of time. If this time is then presented as an hourly rate, i.e. how many hours per week are spent recruiting it does start to add up as a cost. Therefore there was an agreement on an estimated amount.

Training Costs

Again, this is not a formal process and does not usually entail external trainers and overnight accommodation and at first appeared there were no costs. Once again, whilst discussing this it would appear the CEO spends a fair amount of time himself showing his workers how to do tasks. Whilst taking the employee who has been with the company since its inception in 2005, he has in fact had a lot of input from the CEO and has moved from a young unskilled man to a foreman, running a site with men underneath him. Suddenly, the CEO realises he spends a fair amount of time every day showing his team how to do things. Then if they move on/become ill or die, the CEO has to start again with new employees. So we could allocate a percentage of money to training costs, although when employees move on it is not known if it is HIV-related.

Death Benefits

How much does it cost the company when an employee dies? The CEO does not believe this has happened to us at this point hence there have been no death benefits to be paid to the family. However, once considering other costs such as funeral costs and transport to

the funeral, the company has had two incidents where leave has been given to go back to the Eastern Cape to attend funerals. HIV/AIDS was not quoted as being the reasons; one employee's brother was shot and the others sister died from diabetes. The researcher appreciates the stigma and discrimination associated with HIV/AIDS may hinder an employee from informing us it was AIDS so it is difficult to assess. At this time the company has allocated any money for HIV/AIDS related deaths.

Health Care

It is estimated that 20% of South Africans are covered by employment related health insurance with both direct and indirect costs skilled and highly skilled employees would increase from 5% in 2005 to 10% in 2010. Companies carry 50% of the direct costs whilst the employee carries the other half. With regards to the indirect costs, 50% would be passed onto consumers the other 50% has to be absorbed by the company (Booyesen, Geldenhuys & Marinkov 2003). At present there is no health cover from RHC for his workforce of primarily semi-skilled to unskilled men therefore no costs shall be used here.

Results

Your responses:

32 are in the group you wish to analyse.

R 72 000 is the average annual salary of this group.

19.94% is the percentage of your workforce that you estimate is infected.

R525.00 is the total cost of recruiting a new worker

R1428.00 is the total cost of training a new worker.

0.00% is the total cost of death benefits.

Calculation of HIV Infections and Annual Number of New AIDS Cases

Estimated number of HIV+ employees	6
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Estimated number of employees presenting the symptoms of AIDS per year	1
Productivity Losses	R 36 000.00
Cost of Training and Recruitment	R 1 953.00
Annual Cost to your Company	R 37 953.00

The results did highlight HIV/AIDS may well be having an annual cost to Robert Henry Construction, a surprise to the CEO but consistent with research such as that carried out by Ebony Consulting International 2002, whom concluded “HIV/AIDS does appear to be having a negative impact on many SMEs, increasing both direct and indirect costs. Many firms are responding, or trying to respond, but it is difficult for a small business to develop and implement an effective programme” (Fraser et al 2003). Connelly and Rosen (2005) carried out a study addressing the lack of response from small to medium sizes business to acquire an understanding of why this was the case. They concluded that current demand for HIV/AIDS services among small to medium size business in South Africa is minimal. Consistent reasons are: lack of information and access to services, stigma and lack of pressure to act. Connelly and Rosen suggest an information campaign directed at small to medium size business to increase demand for lower-cost services and the use of business and employee association such as the chambers of commerce, trade groups and labour unions. Governments and donor agencies need to understand the differences between SMEs to help the funding of programmes more effectively. As for us, the results highlighted there is no room for complacency as there are real costs which could be mitigated with small, manageable measures.

If a register of construction workers could be established with direct access to them via cell phones, it could open up a whole new way of delivering health promotion messages. There could be a registration pack which employees receive when they register their cell phones numbers, to encourage them to do so. The NHBRC and Master Builder seems a natural first port of call as they have an established register of builders and trade companies.

7. Recommendations and a strategic response

The construction industry's response to HIV/AIDS in the workplace needs to be addressed as soon as possible. The researcher has developed an eight point plan to tackle the barriers all companies face regardless of size.

7.1 Local and national government recognition of the need for an industry specific response

The construction industry, much like all industries, has a unique workplace and faces individual challenges which have been discussed. It is the third most vulnerable sector to HIV/AIDS behind Mining and Transport and could consider their responses for direction. The mining sector is a major segment of the South African economy and will be hit hard by HIV/AIDS. Studies regarding this sector have suggested prevalence rates of one quarter to almost one half of all the countries miners (Smart, 2004). However, in comparison to the construction industry, the mining industry recognised the need to respond back in 1985-6. This was when the very first screening took place to detect HIV amongst mineworkers. In 1988, health care services had been developed with education and awareness campaigns on sexually transmitted diseases and HIV/AIDS. Knowledge, attitudes and practices studies were carried out in 1989, followed by mining companies increasingly introducing HIV/AIDS workplace policies.

In 1993 The SA Chamber of Mines established a standard committee on HIV/AIDS whom commissioned a survey on HIV/AIDS in Southern Africa. The International labour Organisation (ILO) Code on HIV/AIDS in the workplace was developed in 1998 and implemented in 2001. Also in 1998 the South African White Paper on mining and Minerals outlined the need to develop an HIV/AIDS policy recognising the vulnerability of migrant labour, housing and living conditions and the respective responsibilities of government and employer in addressing these issues. It also highlighted the need to protect human and labour rights.

In 2000 the South African Development Community (SADC) established a HIV/AIDS Strategic Framework and Programme of action which has a sector specifically considering the mining industry. Companies such as Debswana by 2001 were introducing

subsidised (90%) ART treatment followed by Anglo America in 2002. These companies recognised the importance of its human resources and how HIV/AIDS could devastate their businesses. In 2003 a summit was held by government, labour and mining companies which resolve that; every workplace will have a programme in place by the end of 2004; prevalence survey results will be shared within a national database framework; and measures will be implemented to improve standards of health and housing.

All these measures demonstrate how HIV/AIDS can be tackled on a multifaceted level bringing together, business, government and labour unions. As recently as 26th of March 2012, Deputy President Kgalema Motlanthe urged the mining sector to improve its HIV/AIDS and TB responses otherwise they could be hit where it hurts-the bottom line. At the same event Mineral Resource Minister, Susan Shabangu announced mining companies will have to submit their HIV/ TB workplace safety policies as a prerequisite for renewing their mining licences. This meeting also saw the Minister of Health, Dr Aaron Motsoaledi and the South African National AIDS Council deputy chairperson, Mark Heywood, come together in support of the miners with issues such as unfair dismissal due to health, poor housing conditions and compensation for their families should they die. This demonstrates government can use its influence to force the private sector to commit to addressing HIV/AIDS in the workplace.

The trucking industry also faces an enormous challenge with prevalence rates being as high as 59% (Johnson & Budlender, 2002) but has also shown innovation whilst considering HIV/AIDS among their work force. Truck driver's lifestyle can often be challenging, working long hours, driving long distances with prolonged loneliness. The latter often means drivers find comfort in the arms of sex workers, who themselves are driven by high unemployment rates, to provide this service. The significance of this being HIV/AIDS has easily been transmitted from one truck stop to another without any bias. The Trucking Wellness Programme was launched in 1999 by the National Bargaining Council for the Road Freight Industry to raise awareness concerning HIV/AIDS and sexually transmitted infections (STI) specifically among long distance truck drivers and commercial sex workers. See the outline of the 22 National Roadside Wellness Centres below.

22 National Roadside Wellness Centres to choose from.



If the industry was left unchecked, HIV/AIDS would have a devastating effect on not only the industry itself but on the country's economy as a whole. Most other sectors are reliant on or are linked to the transport industry as 80% of good are transported by road. The Trucking Wellness Programme was set up in 1999 and runs 22 wellness centres nationally in collaboration with industry partners, local government and health department. It is supported by the Road Freight Association and is managed by the Corridor Empowerment Project with the main focus being on:

- Condom distribution
- STI diagnosing, treatment and education
- HIV awareness, information, education, counselling and testing
- Referrals to appropriate service providers for ART and HIV/AIDS treatment and care
- TB and Malaria awareness, screening and where necessary referrals for treatment
- General health checks such as blood pressure, blood sugars, cholesterol and body mass index or any primary care health problem.

Through this programme many lives have been saved or improved and the once potentially threaten trucking industry has weathered the devastating effects of HIV/AIDS. This is an excellent example of how through public/private cooperation, a solution to complex issues can be found.

7.2 The development of a cohesive response

The construction industry has no cohesive response. Local and national government need to recognise the need for an industry specific response. Harry Lake of Care Works, who provided data for the UCT research paper on HIV/AIDS in the construction Industry, argues a compulsory, industry wide initiative need to be adopted by the South African construction industry to fight the rising prevalence rates among its workers. He comments:

“Because of the male dominated, contract driven and mobile nature of the industry, companies can very easily take the view that it is not their concern. In some areas over half the workers are positive.”

This must mean getting ministers of government on board to back a campaign similar to that of the mining industry. Within the Western Cape the DA should be approached for support.

A campaign should be launched, involving dissemination of information, condom distribution, tackling stigma and discrimination, promoting medical male circumcision (MMC), workplace peer educator programmes, promotion of voluntary counselling and testing (VCT), knowing your HIV status and access to care and treatment. Although this sounds an enormous task it could perhaps be tackled with a one day event aimed at the work force of those in the construction industry. Secondary to a large advertisement campaign, using building supplier's stores, on World Aids Day, 1st of December, a football tournament could be arranged. The newly erected World Cup stadiums could be the venue and a whole day of football fun could go hand in hand with a massive HIV/AIDS campaign. There could be mobile wellness clinic screening for much more than just HIV to take the stigma away from utilizing them, information surrounding health issues and a registration pack for those in the industry who register their cell phone numbers. It should be advertised as a fun day for all the family.

Making condoms available to this work force could be accomplished via the installation of condom vending machines into the hired porter toilets. The majority of building sites, regardless of how small, will have a porter toilet on site hence through the companies whom hire out these toilets could be approached to install condom vending machines.

When a company hires out a porter toilet, they could be given enough condoms to refill the machine pending duration of hiring time and size of work force. They would either be paid for the extra work or offered extra staff to cover this work load and paid for by government or international funding.

The training of peer educators to help reduce stigma and discrimination. This could be organised with the collaboration institutes such as the NHBRC, Master Builders and faith based/private organisation already running such courses.

Mobile clinics to offer onsite testing and testing sites being made available at supplies such as Penny Pinchers, Builders Warehouse Timber Merchants, Concrete Supplies etc.

7.3 Convince large construction companies of the need to embark on HIV/AIDS workplace policies

Large construction companies need to recognise the threat HIV/AIDS is to the industry and implement HIV/AIDS workplace policies. This will require convincing CEO, directors etc. of the impact of HIV/AIDS on their business and offer assistance in developing workplace programmes. They in turn can assist their suppliers/sub-contractors. Incentives must be developed to do so.

7.4 Suppliers support

Suppliers need to recognise the impact HIV/AIDS will have on their business. Builders Warehouse, Penny Pinchers etc. need to be fully supportive of industry specific prevention programmes. These supplies can be used to reach builders and promote “Be Positive About Positive”

7.5 Diversify HIV testing options

More industry friendly testing sites/options. Distribution of wellness packs to include oral HIV home testing kits with support helpline number available 24 hours a day. One of the researcher’s main thoughts is the call for home testing kits. If the South African government is serious about the number of people they want tested and how often they want people to check their status, the traditional VCT is way too cumbersome and the infrastructure in the health care system just not equipped to cope. Home testing would allow those who do not want to go the formal route or who do have access to the formal

VCT a more private, flexible option. Now the Food and Drug Administration (FDA) has approved an oral testing kit the, researchers' concern with regards to the testing kits requiring the individual to pick their finger for blood- is gone. It is now a swab from the upper part of the individual's gums. The South African government has concerns over the home testing kits but Charles King of Housing Works, noted how the arguments against HIV home testing "closely tracked the arguments against over the counter pregnancy tests" in the 1970s. At the time, there was widespread anxiety that adolescents would misuse pregnancy tests (if they could afford them) or that those finding out they were pregnant without professional support would not take confirmatory tests, would not access clinical services, would self-harm and would suffer violence from their parents or boyfriend. These fears turned out to be largely unfounded.

Advocates for home testing kits believe the key advantage is that it puts testing into the hands of the individual rather than being controlled by health care professionals. Those who have had many previous tests may not require or want the in-person counselling with advocates suggesting individuals should be able to decide how they receive information about their own bodies (Pebody, 2012). Respondents from a survey carried out in France which recruited 9 000 men who filled in a survey online highlighted 31.5% reported the main reasons for interests in home testing kits are convenience and accessibility, 28.5% suggested it's rapidity with 23.5% quoting privacy as a benefit (Pebody, 2012). One of the comments made by a company CEO who filled in this researcher's questionnaire was his men work the hours in which the clinics are open so if these kits could be made readily available, these particular barriers could be overcome. Dr Helen Ayles in Zambia, carrying out the ZAMSTAR study suggests:

"I think this is coming whether people like it or not, and it's already happening on quite a scale in South Africa" (cited from Alcom, 2010).

Research carried out by Dr Lix Corbett, of the London School of Hygiene and Tropical Medicine, based in Malawi has found when it comes to comparing door to door VCT conducted by health care workers, the possibility of self-testing was much more appealing. She conducted a study of 260 randomly selected Malawian and offered 91% of this group the opportunity to carry out the oral HIV test with 99.2% getting the test right first time. Dr Corbett comments:

“Withholding a fabulous diagnostic tool from the population because of concerns about their ability to handle it seems lunacy to me” (cited in Pebody, 2012).

Whilst discussing the use of home testing kits she suggests the most common feedback she observes is why are these tests not available and why isn't the government distributing them to everyone?

There are those who are a little more cautious whilst considering these kits as Jeremiah Chakay, who heads the National TB control programme in Kenya. He pointed out a recent case where a Kenyan policeman who went on a rampage shooting ten people once he found out he was HIV positive. Clearly a massive effort to reduce stigma and discrimination is also of a high priority.

Occupational Health Nurses to offer onsite testing. To engage with established companies such as Care Works to organise VCT, information distribution and the training of peer educators.

7.6 Incentives for employers to have an active HIV/AIDS workplace policy

Tax incentives for those companies who have active HIV/AIDS workplace policies. If it is estimated a workplace policy cost anything from 0.8% - 2% of annual pre-tax turnover-offer this back in tax incentives.

7.7 Incentives for employees to know their status

Incentives for employees who participate in HIV/AIDS workplace programmes. A vitality type incentive card could be developed specifically for construction worker employees i.e. gain points for getting tested, entering of competitions to win prizes and vouchers (get on board Clicks and Pick 'n' Pay etc.). Companies can offer incentives such as a gift card, loans training if employees come on board and participate in the wellness programmes.

On the 25th of November 2011, Helen Zille, Premier of the Western Cape launched a campaign of 16 days of Activism for No Violence against Women and Children called, “Know Your Status and Win/Weet en Wen” She comments; “Persuasion has not particularly worked. We have done everything. We would rather use incentives to ensure

that all adults regularly test their status. We are not going to push and coerce. We are going to incentivise people to take responsibility. Preliminary indications are that the incentive scheme significantly increased the number of people being tested, both at our network of clinics and at the special sites set up for the project,” Zille commented November 2011 (Kamaldien, 2011).

Under the campaign, every citizen who took an HIV test at any of the 204 Western Cape government testing sites where entered a draw where they could win R50 000 1st prize and five R10 000 rand prize money. Incentives do appear to work.

A collaborate approach involving local and national government, big business, NGO, international aids programmes etc. is required to seriously tackle HIV within the construction industry.

7.8 Use of technology

Develop more sophisticated methods of delivering workplace programme such as a Mobile Health Solutions. Involve Vodacom, M-Net etc. to text message health promotion information via fun quizzes where prizes such as free airtime can be won. Look at other such initiatives such as that by Professor Henry Nyongesa, University of Botswana who is developing an internet bases health care information service. This initiative is an internet health based service that can process text-message queries from cell phone users and deliver relevant information about how to manage chronic illnesses such as HIV/AIDS. Professor Nyongesa states:

“We believe that using the text messaging capabilities of mobile phones to deliver medical information can greatly increase HIV/AIDS awareness and prevention, especially in underprivileged communities. Particularly in areas such as Sub-Sahara Africa, where computer literacy is still low, mobile telephony represents the most promising solution”. Henry Nyongesa, professor of computer science at the University of Botswana (Microsoft Research Corporation, 2007).

The researcher believes much could also be learnt from Katali Rise who has implemented a “Text for Change” quiz in Uganda. This campaign saw the creation of a SMS programme to increase HIV/AIDS awareness in Northern Uganda, increase the uptake of

HIV testing, to encourage people to seek care and treatment in order to decrease further HIV transmission. Though the use of radio commercials people were asked to subscribe to the Text to Change HIV/AIDS quiz which consisted of 19 questions assessing the individuals knowledge of HIV/AIDS as well as retrieving demographic information. It targeted a group 145 000 people in the North West Region and a further 70 000 people in Lira, with questions regarding HIV/AIDS and encouragement for people to test for free at the Aids Information Centre. Apart of other results HIV testing at the Lira Aids Centre increased considerable and 96% of all those surveyed stated they had gained new knowledge secondary to it. To date 4,005,615 text messages have been sent out (and still counting) (Microsoft Research Corporation, 2007)

7.9 Support from professional organisations within or involved with the construction industry

The NHBRC, Masters Builder, the Construction Industry Development Board and the Chamber of Commerce must support the implementation of HIV/AIDS workplace policies within the construction industry. Having a policy should be part of the application process for the NHBRC and Master Builders. They could also incorporate HIV/AIDS awareness programmes into their health and safety department, running courses for free on weekends and training of peer educators. These institutions could also carry out KAP studies and these results could influence the prevention programmes.

8. Conclusion

Traditionally, large corporations and government bodies have been seen to be in an ideal position to manage their human resources in a professional manner. Large companies may even have a Human Resources Department, with personnel professionally trained to deal with everything from hiring staff to organising medical benefits. Smaller companies do not habitually consider formally organising their human resources which this researcher originally agreed with. However, several alarming factors came to the researcher's attention which changed this opinion 100%. Firstly, the world now lives in an era of HIV/AIDS: secondly, South Africa has an alarming prevalence rate and lastly, within sub-Sahara Africa small to medium size businesses employs a large percentage of the workforce. Whilst considering the construction industry, the third most vulnerable within South Africa there is no cohesive response for managing HIV/AIDS in the workplace.

This is especially true for small building companies. The researcher wanted to consider why this was so.

Several findings have emerged from this research, one being; of those surveyed none of the respondents felt that HIV/AIDS was not a long term problem for the construction industry. Despite this 83% have not implemented a workplace policy, with 63% commenting they still do not see any effect. Of the 17% who do have a policy, 92% have no formal prevention, awareness or treatment campaign but informal chats appear to be the intervention. Reasons cited for not implementing a more formal attack on HIV/AIDS in the workplace is: a lack of visibility, no need as staff are HIV free, cost, time, firm too small, employees privacy, and do not know how. One CEO of a company indicated he knew two of his staff had died from AIDS but by the time he knew about their status it was too late. Whilst considering the financial viability of a treatment campaign 45% had no idea of costs. The construction industry must have assistance recognising the problem HIV/AIDS will have on it and be guided how to mitigate it. The researcher hopes through this research and the development of a strategic response that there can be light at the end of a very dark tunnel.

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Appendix 1

Factors Hindering Adoption of HIV/AIDS Workplace Policies:

- HIV/AIDS not a priority business issue
- No visible HIV/AIDS impact
- No staff participation in the activities of HIV/AIDS institutions
- Absence of HIV legislation
- Lack of top management support
- No expertise available
- Lack of awareness of other companies' response
- Weak unionism
- Lack of financial resources. Basic cost of the project

Appendix 2

Example of cost of workplace HIV/AIDS programme:

TOTAL CONTRACT VALUE = R 3 300 000.00

HIV/AIDS=0.12% OF TOTAL CONTRACT VALUE

Training (4 workshops) *R 1,200.00*

Booklets *R 896.88*

Awareness champion *FREE*

Video *R 24.61*

Posters *R 129.92*

Condom dispensers *R 390.00*

CONDOMS (200 female) *R 1,224.00*

Monitoring *FREE*

Tools down *FREE*

APPROXIMATE TOTAL

COST R 3,865.41

Appendix 3

HIV/AIDS INTERVENTION SURVEY

SECTION A: COMPANY INFORMATION

1. Position/Job Title

2. Which construction works category do you primarily belong to? (tick all applicable)

- ☐ Site preparation
- ☐ Construction of buildings
- ☐ Construction of other buildings
- ☐ Construction of other structures
- ☐ Construction by specialist trade contractors
- ☐ Plumbing
- ☐ Electrical contractors
- ☐ Shop fitting
- ☐ Other building installation
- ☐ Painting and decorating
- ☐ Other building completion

3. How many permanent employees do you have?

- ☐ < 5
- ☐ 5-10
- ☐ 10-20
- ☐ 20-30
- ☐ 30-40
- ☐ 40-50

4. How many non- permanent/informal employees do hire over a three month period?

- ☐ < 5
- ☐ 5-10

- ☐ 10-20
- ☐ 20-30
- ☐ 30-40
- ☐ 40-50

5. What is your average annual turnover for your firm?

- ☐ < 750 000
- ☐ 750 000-3 million
- ☐ 3-6 million
- ☐ > 6 million

SECTION B: COMPANY PERCEPTION AND POLICY

1. How does your company rate (perceive) the threat of HIV/AIDS as a long term problem in the Construction Industry?

Perception of HIV/AIDS

Significant problem Problem Neutral Slight Problem Not a problem

☐ ☐ ☐ ☐ ☐

2. Does your company have a HIV/AIDS policy?

- ☐ Yes
- ☐ No

Answer the following question only if your response to the above question (question 2) was YES.

If your response was NO proceed to question 4.

3. Which of the following does the policy involve?

- ☐ Awareness
- ☐ Prevention
- ☐ Treatment

Other (please specify)

4. If your answer is NO to Question 2 is it because (tick more than one if applicable):

- ☐ You do not considered HIV/AIDS as a workplace concern
- ☐ HIV/AIDS not a priority business issue
- ☐ There is no visible HIV/AIDS impact on the operations of the company
- ☐ No staff participation in the activities of HIV/AIDS institutions
- ☐ Lack of financial resources
- ☐ HIV/AIDS a sensitive issue
- ☐ Staffs sexual behaviour is a personal issue
- ☐ Other, please specify

AWARENESS

1. Does your company have a HIV/AIDS awareness campaign?

- ☐ Yes
- ☐ No

2. If YES to Question 1: when was it implemented in your company?

- ☐ 1981-1985
- ☐ 1986-1990
- ☐ 1991-1995
- ☐ 1996-2000
- ☐ 2000-2005
- ☐ 2005 after
- ☐ Do not know

3. If YES to Question 1: What does your company's AWARENESS campaign involve?

4. If NO to Question 1: why have you not implemented such a campaign?

PREVENTION

1. Does your company have a HIV/AIDS PREVENTION campaign?

☐ Yes

☐ No

2. If YES to Question 1: When was it implemented?

☐ 1981-1985

☐ 1986-1990

☐ 1991-1995

☐ 1996-2000

☐ 2000-2005

☐ 2005 after

☐ Do not know

3. If YES to question 1: what does your company's HIV/AIDS PREVENTION campaign involve?

4. If NO to question 1: why have you not implemented such a campaign? TREATMENT

1. Does your company have an HIV/AIDS TREATMENT programme?

☐ Yes

☐ No

2. If YES to question 1: when was it implemented in your company?

☐ 1981-1985

☐ 1986-1990

☐ 1991-1995

☐ 1996-2000

☐ 2000-2005

☐ 2005 after

Do not know

3. If YES to question 1: what does your company's HIV/AIDS programme involve?

4. If NO to question 1: why have you not implemented such a programme?

SECTION C: HIV/AIDS EMPLOYEES

1. Do you encourage employees to know their HIV status?

☐ Yes

☐ No

2. In your opinion, what percentage of the permanent staff are HIV positive?

None

☐ 1-5%

☐ 6-10%

☐ 11-15%

☐ 16-20%

☐ 21-25%

☐ 26-30%

☐ 31-35%

☐ 36-40%

☐ 41-45%

☐ 46-50%

☐ > 50%

☐ Do not know

SECTION D: COMPANY INVOLVEMENT & HIV/AIDS

1. In your opinion, is it financially viable for your organisation to run an HIV/AIDS treatment programme?

☐ Yes

☐ No

Do not know

2. Please provide a reason for your answer to Question 1:

THANK YOU

Thank you for your participation in this survey; your information will be highly valued in our on-going research study into

HIV/AIDS within the construction industry. If you would like to receive a copy of the results please insert an email address below. Your email address will be kept confidential.